Excellus
165 Court Street, Rochester, NY 14647
A nonprofit independent licensee of the BlueCross BlueShield Association

GROUP ENROLLMENT FORM
MONROE COUNTY

DO NOT USE - MICROFILM ONLY

Instructions on Back. All Dates = mm/dd/yy ❑ **Check if name change** ❑ **Check if new address** **Please print clearly.**

✓ CHECK DESIRED ACTION	✓ CHECK DESIRED COVERAGE - Select One Product Option	✓ CHECK PERSON(S) COVERED			
❑ Add Subscriber (AA) Date of Hire/Event ___ / ___ / ___ Coverage Eff Date ___ / ___ / ___	❑ Blue Point 2 Extended 1 -065 (SE) ❑ Blue Point 2 Extended 2 -063 (IN) ❑ Blue Point 2 Select 1-066 (TP) ❑ Blue Point 2 Select 2-064 (TV) ❑ Blue Point 2 Value -067 (SV) ❑ Blue Million - 010 (TR)	Self, Spouse & Child(ren) (A) ❑	Self & Child (B) ❑	Self & Spouse (C) ❑	Self (D) ❑

❑ Add Dependent (AB)
Date of Event ___ / ___ / ___
Coverage Eff Date ___ / ___ / ___

❑ Change Coverage (AC)
Coverage Eff Date ___ / ___ / ___

❑ Transfer to COBRA (AD)
❑ (S)ubscriber
❑ (M) Dependent
❑ (D)isabled
Date of Event ___ / ___ / ___

❑ Cancel Subscriber (S)
❑ Cancel Dependent (M)
❑ (M)edical
Reason Code (see back)___________
Cancellation Date ___ / ___ / ___

SUBSCRIBER INFORMATION - Must be completed

Social Security # :|__|__|__|-|__|__|-|__|__|__|__| Sex: ❑ M ❑ F Birthdate ___ / ___ / ___

Last Name________________________________ First________________________________

Street____

City______________________________ State__________ Zip__________

Day Phone:|__|__|__|-|__|__|__|-|__|__|__|__|

Blue Point 2 members must select a **Medical Center OR Primary Care Physician (PCP)**. Females may also select an OB/GYN.

Check Medical Center*: ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton — Current Patient?

Primary Provider (Last) ________________(First)______________________________ ❑ Y ❑ N

OB/GYN Provider (Last) ________________(First)______________________________ ❑ Y ❑ N

FAMILY MEMBER INFORMATION ✓ **Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.**

Relationship / Name	Social Security #	Sex	Birthdate (mm/dd/yy)	Medical Center	Physician
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ (F)oster/Grandchild Dependent ❑ Other________________ *Last Name (if different)* *First Name*	Social Security #	Sex ❑ M ❑ F	Birthdate (mm/dd/yy) ___/___/___	Medical Center ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton	Primary Care Physician Current patient? ❑ Y ❑ N Last First OB/GYN Physician Current patient? ❑ Y ❑ N Last First
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ (F)oster/Grandchild Dependent ❑ Other________________ *Last Name (if different)* *First Name*	Social Security #	Sex ❑ M ❑ F	Birthdate (mm/dd/yy) ___/___/___	Medical Center ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton	Primary Care Physician Current patient? ❑ Y ❑ N Last First OB/GYN Physician Current patient? ❑ Y ❑ N Last First
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ (F)oster/Grandchild Dependent ❑ Other________________ *Last Name (if different)* *First Name*	Social Security #	Sex ❑ M ❑ F	Birthdate (mm/dd/yy) ___/___/___	Medical Center ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton	Primary Care Physician Current patient? ❑ Y ❑ N Last First OB/GYN Physician Current patient? ❑ Y ❑ N Last First
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ (F)oster/Grandchild Dependent ❑ Other________________ *Last Name (if different)* *First Name*	Social Security #	Sex ❑ M ❑ F	Birthdate (mm/dd/yy) ___/___/___	Medical Center ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton	Primary Care Physician Current patient? ❑ Y ❑ N Last First OB/GYN Physician Current patient? ❑ Y ❑ N Last First

OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information.
In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.
Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Medicare or Medicaid)?

❑ Yes ❑ No ✓ Check: ❑ Medical Are you keeping this coverage? ❑ Yes ❑ No

✓ Check previous insurance company from list below and indicate ID #:______________________________

❑ (B) Excellus BlueCross BlueShield, Rochester Region
❑ (O) Other - BlueCross BlueShield Plan Indicate Plan Name:______________________________
❑ (C) Other Carrier - Indicate Plan Name:______________________________

RELEASE - You must sign and date this form to be eligible for insurance.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature______________________________ **Date**__________________

EMPLOYER INFORMATION (Must be completed by Group Representative)

Coverage	Group/Subgroup	Chk Digit	Pkg #	Employer Name MONROE COUNTY
Medical				Employee Status ❑ (A)Active ❑ (A)COBRA ❑ **(A)Cancellation** ❑ (R)etired
				Group Rep Signature/Date

Instructions for completing the Group Enrollment Form

DESIRED ACTION Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 60 days of the Event Date. Please see your Group Representative for events that fall outside the 60-day period. If New Add Subscriber or Add Dependent, you **must** also check Persons covered and Family Member Information section.

Cancel Request
To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber (S) Box
- check Products to be cancelled (Medical)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible
PC – Preferred Care
CP – Commercial
CB - Cobra Begin Date
CD - Cobra Disabled Date
CE - Cobra End Date
SR – Subscriber Request
SD – Subscriber Deceased
SB - Spouse's BCBSRA
MC - Medicaid

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

Cancel Dependent Reasons

MA - Marriage
OA - Dependent Over Age
DM - Deceased
MB - COBRA Begin Date
MR - Subscriber Request
DV - Divorce

If the only change is one of the following, please call Customer Service at the number listed below. A Group Enrollment Form is not required.
➢ Address ➢ Birthdate ➢ PCP ➢ OB/GYN ➢ Medical Center

DESIRED COVERAGE Please check with your group representative.

SUBSCRIBER If you are retired and Medicare eligible, complete the Medicare Eligible - Group Enrollment Form.
If you are disabled, see your Group Representative to determine eligibility for OBRA. If eligible, complete the appropriate form.

FAMILY MEMBER INFORMATION Use an additional form, if more than four persons.
QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Dependents are unmarried children, natural, step or adopted under age 19.
- Dependents over age 19 up to their 23rd birthday can be covered, provided they are full-time students (at least 12-credits/semester). Proof of college enrollment may be required.
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.** Dependents after adoption, grandchild or foster dependents, dependents for whom employee/subscriber has legal custody or legal guardianship, or a handicapped dependent who is over the dependent age for your employer group.

RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accept coverage under the terms of the contract applicable to my coverage (who may include, for example, my spouse and my eligible family dependents).
- I hereby accept responsibility for payment of any portion of the premium.
- I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.

EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Representative.
Complete only the coverage section (Medical) that is applicable to the employee's request.

If you have any questions, please contact Customer Service at:
Excellus BlueCross BlueShield, Rochester Region 1-800-847-1200
Or visit our Web site at www.excellusbcbs.com